Douglas E Paull

List of Publications by Year
in descending order

65 papers	2,169 citations	361045 20 h-index	223531 46 g-index
67 all docs	67 docs citations	67 times ranked	1792 citing authors

#	Article	IF	Citations
1	Association Between Implementation of a Medical Team Training Program and Surgical Mortality. JAMA - Journal of the American Medical Association, 2010, 304, 1693.	3.8	859
2	Evaluation and Management of Massive Lower Gastrointestinal Hemorrhage. Annals of Surgery, 1989, 209, 175-180.	2.1	164
3	Occult Diaphragmatic Injury from Stab Wounds to the Lower Chest and Abdomen. Journal of Trauma, 1989, 29, 292-298.	2.3	111
4	Association Between Implementation of a Medical Team Training Program and Surgical Morbidity. Archives of Surgery, 2011, 146, 1368.	2.3	105
5	Choice of First Intervention is Related to Outcomes in the Management of Empyema. Annals of Thoracic Surgery, 2009, 87, 1525-1531.	0.7	88
6	Root Cause Analysis Reports Help Identify Common Factors In Delayed Diagnosis And Treatment Of Outpatients. Health Affairs, 2013, 32, 1368-1375.	2.5	68
7	Briefing guide study: preoperative briefing and postoperative debriefing checklists in the Veterans Health Administration medical team training program. American Journal of Surgery, 2010, 200, 620-623.	0.9	65
8	Predictors of successful implementation of preoperative briefings and postoperative debriefings after medical team training. American Journal of Surgery, 2009, 198, 675-678.	0.9	58
9	Reperfusion injury in the lung preserved for 24 hours. Annals of Thoracic Surgery, 1989, 47, 187-192.	0.7	45
10	Medical team training and coaching in the veterans health administration; assessment and impact on the first 32 facilities in the programme. Quality and Safety in Health Care, 2010, 19, 360-364.	2.5	43
11	Oxygen free radical scavengers decrease reperfusion injury in lung transplantation. Annals of Thoracic Surgery, 1990, 50, 204-210.	0.7	42
12	Determinants of quality of life in patients following pulmonary resection for lung cancer. American Journal of Surgery, 2006, 192, 565-571.	0.9	39
13	The Effect of Simulation-Based Crew Resource Management Training on Measurable Teamwork and Communication Among Interprofessional Teams Caring for Postoperative Patients. Journal of Continuing Education in Nursing, 2013, 44, 516-524.	0.2	39
14	Alcohol Abuse Predicts Progression of Disease and Death in Patients with Lung Cancer. Annals of Thoracic Surgery, 2005, 80, 1033-1039.	0.7	34
15	Complications and long-term survival for alcoholic patients with resectable lung cancer. American Journal of Surgery, 2004, 188, 553-559.	0.9	28
16	Wrong-Side Thoracentesis. JAMA Surgery, 2014, 149, 774.	2.2	26
17	Errors upstream and downstream to the Universal Protocol associated with wrong surgery events in the Veterans Health Administration. American Journal of Surgery, 2015, 210, 6-13.	0.9	25
18	Effective followership: A standardized algorithm to resolve clinical conflicts and improve teamwork. Journal of Healthcare Risk Management: the Journal of the American Society for Healthcare Risk Management, 2015, 35, 21-30.	0.3	24

#	Article	IF	Citations
19	Management of aortobronchial fistula with graft replacement and omentopexy. Annals of Thoracic Surgery, 1990, 50, 972-974.	0.7	21
20	The effects of crew resource management on teamwork and safety climate at Veterans Health Administration facilities. Journal of Healthcare Risk Management: the Journal of the American Society for Healthcare Risk Management, 2018, 38, 17-37.	0.3	21
21	Improved lung preservation using a dimethylthiourea flush. Journal of Surgical Research, 1989, 46, 333-338.	0.8	20
22	Sharing Lessons Learned to Prevent Incorrect Surgery. American Surgeon, 2012, 78, 1276-1280.	0.4	19
23	Nursing Crew Resource Management. Journal of Nursing Administration, 2013, 43, 122-126.	0.7	19
24	Anesthesia Adverse Events Voluntarily Reported in the Veterans Health Administration and Lessons Learned. Anesthesia and Analgesia, 2018, 126, 471-477.	1.1	18
25	MYCOBACTERIUM KANSASII EMPYEMA IN A RENAL TRANSPLANT RECIPIENT CASE REPORT AND REVIEW OF THE LITERATURE. Transplantation, 2003, 76, 270-271.	0.5	15
26	Assessment of Incorrect Surgical Procedures Within and Outside the Operating Room. JAMA Network Open, 2018, 1, e185147.	2.8	15
27	Positron Emission Tomography in Well Differentiated Fetal Adenocarcinoma of the Lung. Clinical Nuclear Medicine, 2006, 31, 213-214.	0.7	11
28	The Role of the Operating Room Nurse Manager in the Successful Implementation of Preoperative Briefings and Postoperative Debriefings in the VHA Medical Team Training Program. Journal of Perianesthesia Nursing, 2010, 25, 302-306.	0.3	11
29	Handovers During Anesthesia Care. JAMA - Journal of the American Medical Association, 2018, 319, 125.	3.8	11
30	Department of Veterans Affairs Chief Resident in Quality and Patient Safety Program. American Journal of Medical Quality, 2016, 31, 598-600.	0.2	9
31	Root Cause Analysis of Oncology Adverse Events in the Veterans Health Administration. Journal of Oncology Practice, 2018, 14, e579-e590.	2.5	9
32	Root Cause Analysis of Reported Patient Falls in <scp>OR</scp>s in the Veterans Health Administration. AORN Journal, 2018, 108, 386-397.	0.2	9
33	Detection of Occult Thymoma During Exercise Thallium 201, Technetium 99m Tetrofosmin Imaging for Coronary Artery Disease. Chest, 2000, 118, 550-551.	0.4	8
34	Resident Well-Being and Patient Safety: Recognizing the Signs and Symptoms of Burnout. Journal of Oral and Maxillofacial Surgery, 2017, 75, 657-659.	0.5	8
35	Curriculum Development and Implementation of a National Interprofessional Fellowship in Patient Safety. Journal of Patient Safety, 2018, 14, 127-132.	0.7	8
36	A Theory-Integrated Model of Medical Diagnosis. Journal of Cognitive Engineering and Decision Making, 2016, 10, 14-35.	0.9	7

#	Article	IF	Citations
37	Examining Wrong Eye Implant Adverse Events in the Veterans Health Administration With a Focus on Prevention: A Preliminary Report. Journal of Patient Safety, 2018, 14, 49-53.	0.7	7
38	How Well Do Incident Reporting Systems Work on Inpatient Psychiatric Units?. Joint Commission Journal on Quality and Patient Safety, 2019, 45, 63-69.	0.4	7
39	Wrong Site Spine Surgery in the Veterans Administration. Clinical Spine Surgery, 2019, 32, 454-457.	0.7	6
40	Thoracoscopic Talc Pleurodesis for Recurrent, Symptomatic Pleural Effusion Following Cardiac Operations. Surgical Laparoscopy, Endoscopy and Percutaneous Techniques, 2003, 13, 339-344.	0.4	5
41	Preventing Wrong-Site Invasive Procedures Outside the Operating Room. Simulation in Healthcare, 2013, 8, 52-60.	0.7	5
42	Institutional disclosure: Promise and problems. Journal of Healthcare Risk Management: the Journal of the American Society for Healthcare Risk Management, 2014, 33, 24-32.	0.3	5
43	Retained Guidewires in the Veterans Health Administration. Journal of Patient Safety, 2018, Publish Ahead of Print, e911-e917.	0.7	5
44	Sharing lessons learned to prevent incorrect surgery. American Surgeon, 2012, 78, 1276-80.	0.4	5
45	Retained Guidewires. Proceedings of the International Symposium of Human Factors and Ergonomics in Healthcare, 2014, 3, 214-216.	0.2	4
46	Investigating Medical Diagnosis: Qualitative Results from a Virtual Patient Simulation Pilot Study. Proceedings of the International Symposium of Human Factors and Ergonomics in Healthcare, 2015, 4, 92-96.	0.2	3
47	A Review of Adverse Event Reports From Emergency Departments in the Veterans Health Administration. Journal of Patient Safety, 2020, Publish Ahead of Print, e898-e903.	0.7	3
48	Failure to obtain microbiological culture and its consequence in a mesh-related infection. BMJ Case Reports, 2013, 2013, bcr2013009123-bcr2013009123.	0.2	3
49	Surgical Programs in the Veterans Health Administration Maintain Briefing and Debriefing Following Medical Team Training. Joint Commission Journal on Quality and Patient Safety, 2014, 40, 235-239.	0.4	2
50	Work Domain Analysis Applied to Medical Diagnosis. Proceedings of the International Symposium of Human Factors and Ergonomics in Healthcare, 2014, 3, 157-161.	0.2	2
51	Root Cause Analyses of Reported Adverse Events Occurring During Gastrointestinal Scope and Tube Placement Procedures in the Veterans Health Association. Journal of Patient Safety, 2020, 16, 41-46.	0.7	2
52	The Effect of Alcoholism on the Prognosis of Stage III and IV Non-small Cell Lung Cancer. Chest, 2004, 126, 769S.	0.4	1
53	Sharing Lessons Learned to Prevent Adverse Events in Anesthesiology Nationwide. Journal of Patient Safety, 2021, 17, e343-e349.	0.7	1
54	Gene expression profiles from needle biopsies provide useful signatures of non-small cell lung carcinomas. Biomarker Insights, 2007, 2, 253-9.	1.0	1

#	Article	IF	Citations
55	Invited commentary. Annals of Thoracic Surgery, 2006, 82, 1204.	0.7	0
56	Invited commentary. Annals of Thoracic Surgery, 2007, 84, 202.	0.7	0
57	Gene Expression Profiles from Needle Biopsies Provide Useful Signatures of Non-Small Cell Lung Carcinomas. Biomarker Insights, 2007, 2, 117727190700200.	1.0	0
58	The Relationship Between Beer Consumption and Lung Cancer. , 2009, , 657-668.		0
59	Improving Patient Safety through Educational Initiatives. Proceedings of the Human Factors and Ergonomics Society, 2013, 57, 1527-1530.	0.2	0
60	Board #151 - Research Abstract Training for Time-Outs Prior to Invasive Procedures. Simulation in Healthcare, 2014, 9, 426.	0.7	0
61	Surgical Stapler Adverse Events in the Veterans Health Administration. Proceedings of the International Symposium of Human Factors and Ergonomics in Healthcare, 2014, 3, 153-156.	0.2	0
62	The Human Factors of Continuous Subcutaneous Insulin Infusion: Modeling Insulin Pump Use Issues. Proceedings of the International Symposium of Human Factors and Ergonomics in Healthcare, 2015, 4, 124-128.	0.2	0
63	Virtual Patient Simulation. Proceedings of the Human Factors and Ergonomics Society, 2016, 60, 533-537.	0.2	0
64	Results from a simulation based medical team training curriculum utilizing an observational learning model. MedEdPublish, 0, , .	0.3	0
65	Incorrect Surgery and Invasive Procedures: Internet Videos Fail to Depict the Full Story. Advances in Intelligent Systems and Computing, 2018, , 469-476.	0.5	0